

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/15/2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/22/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/04/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/30/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/16/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/2007 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/02/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/12/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 03/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 9	Number of induced terminations 3	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (in weeks) 9	Post fertilization age of the fetus (in weeks) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 03/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/15/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/16/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 1	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 09/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/27/2015 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/26/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 06/20/2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/2009 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 06/20/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/29/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/2009 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/28/2014 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

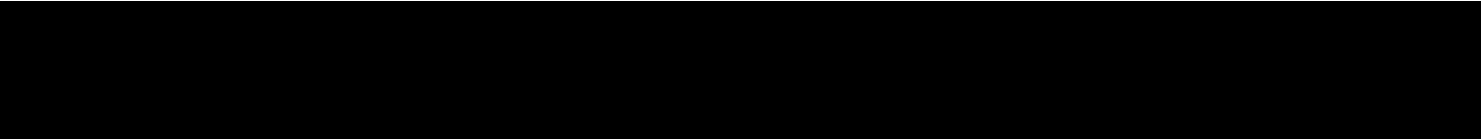
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/02/2015	Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 6	Number of induced terminations 0

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (in weeks) 9	Post fertilization age of the fetus (in weeks) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

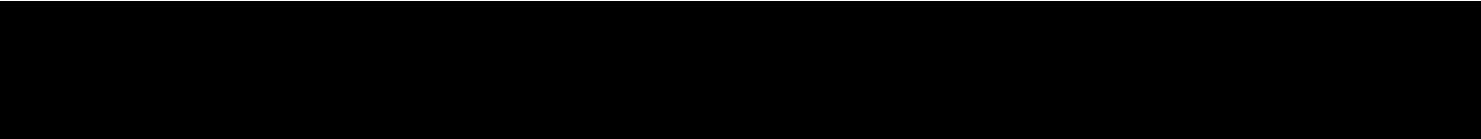
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/04/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 03/05/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Did this termination of pregnancy result in a maternal death?
☐ Yes ☒ No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)
For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/02/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/29/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 03/2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 05/22/2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/27/2015 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 05/2001 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education Master's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/05/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input checked="" type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Doctorate/Professional Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 05/23/2013 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2012 3. 2014 4. 2014 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 43	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Unknown
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

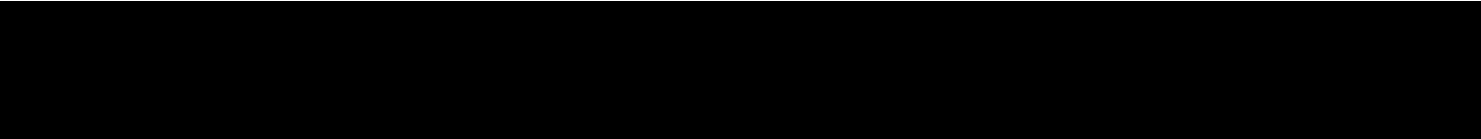
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/23/2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Some College, No Degree
Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (Do not include this termination. If more than six (6), those most recent.)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/18/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (in weeks) 8	Post fertilization age of the fetus (in weeks) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 05/22/2014 2. 3. 4. 5. 6.

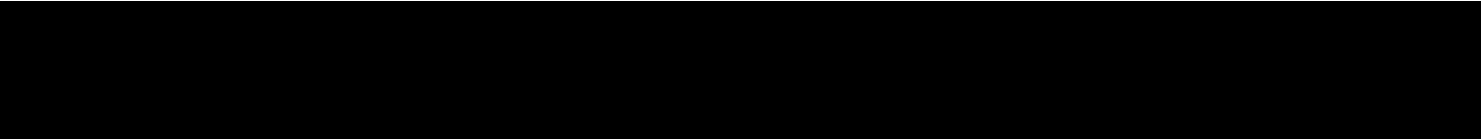
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/02/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 43	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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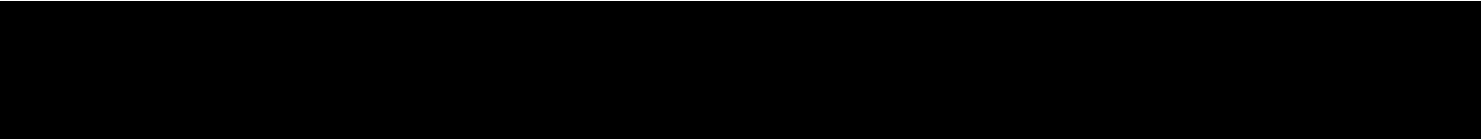
Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (in weeks) 10	Post fertilization age of the fetus (in weeks) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

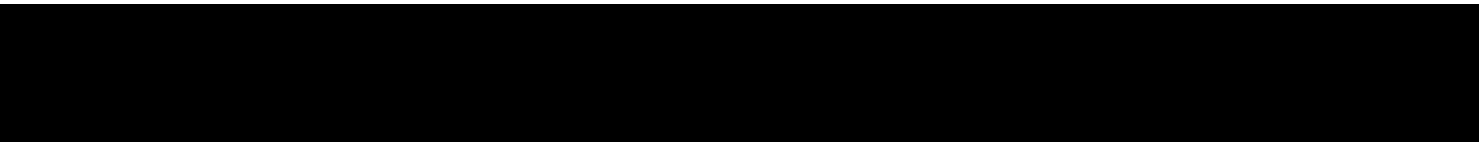
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/25/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (Do not include this termination. If more than six (6), those most recent.)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/04/2016	Physician estimate of gestation (in weeks) 8	Post fertilization age of the fetus (in weeks) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 06/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1998 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 11/16/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/01/2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 10/26/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/31/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/03/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/04/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 44	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 1	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

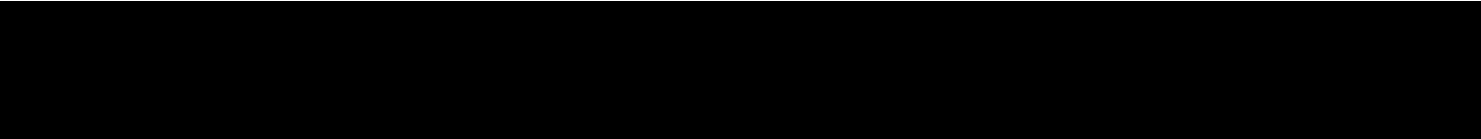
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (Do not include this termination. If more than six (6), those most recent.)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (in weeks) 9	Post fertilization age of the fetus (in weeks) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

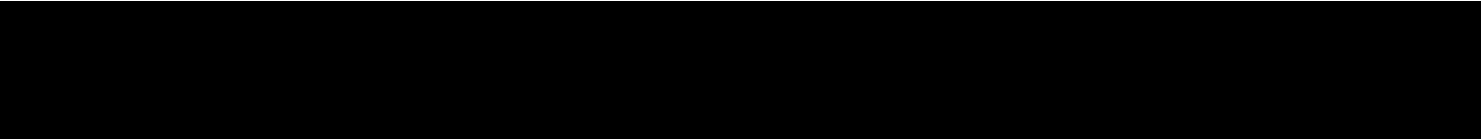
Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 09/04/2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 09/12/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/24/2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 06/19/2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 05/13/2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

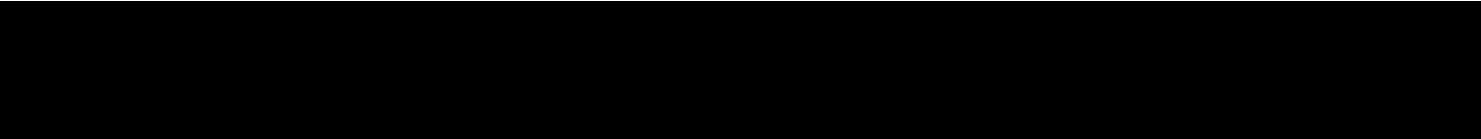
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/17/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

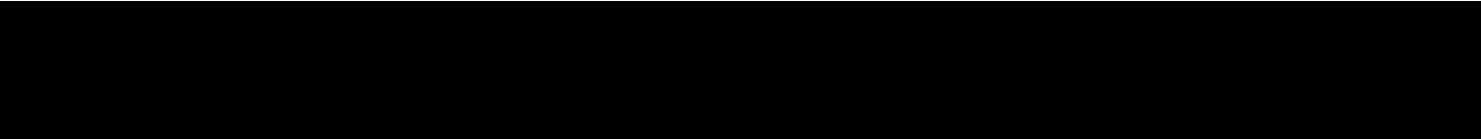
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/18/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

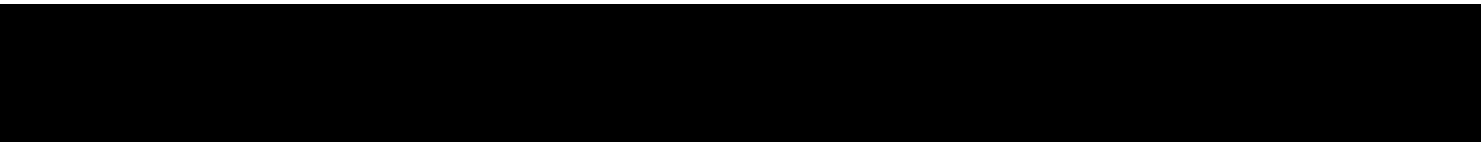
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/01/2015 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 04/17/2014 2. 05/21/2015 3. UNKNOWN 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

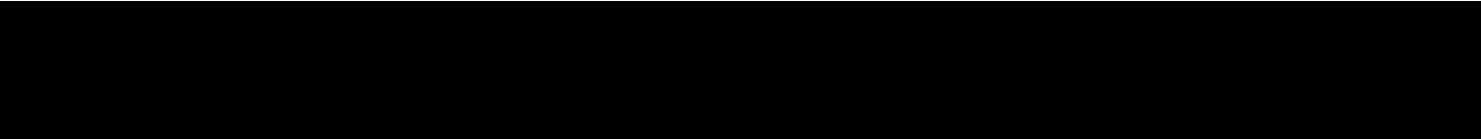
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/29/2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 01/08/2016 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 03/31/2006 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 08/22/2011 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 44	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/31/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 11/27/2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

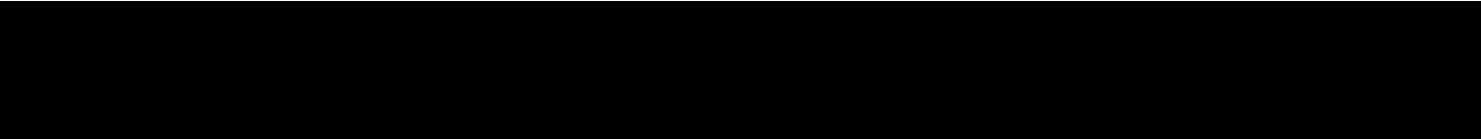
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (in weeks) 10	Post fertilization age of the fetus (in weeks) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

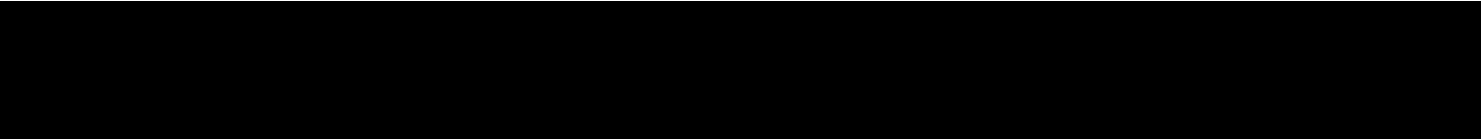
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/24/2016	Physician estimate of gestation (in weeks) 13	Post fertilization age of the fetus (in weeks) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Master's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/19/2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (Do not include this termination. If more than six (6), those most recent.)
1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (in weeks) 11	Post fertilization age of the fetus (in weeks) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 10	Number of induced terminations 4

Dates of terminations (Do not include this termination. If more than six (6), those most recent.)					
1. 01/14/2016	2. UNKNOWN	3. UNKNOWN	4. UNKNOWN	5. UNKNOWN	6. UNKNOWN

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/01/2009 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 09/24/2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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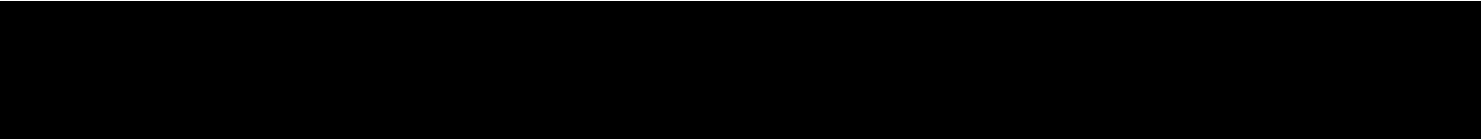
Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Did this termination of pregnancy result in a maternal death?
☐ Yes ☒ No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 04/2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2008 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 11/01/2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND++		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 04/05/2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/05/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/07/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/23/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/01/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/29/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/22/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/15/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 04/30/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (in weeks) 8	Post fertilization age of the fetus (in weeks) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/31/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

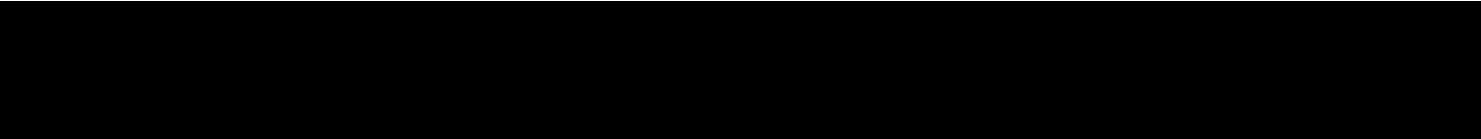
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 01/24/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/29/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 09/14/2015 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (in weeks) 6	Post fertilization age of the fetus (in weeks) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/04/2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

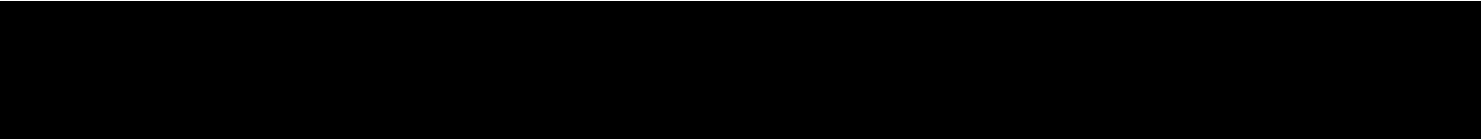
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/19/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/26/2016 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/31/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
---	--	--

How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 11/20/2014 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/19/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/31/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

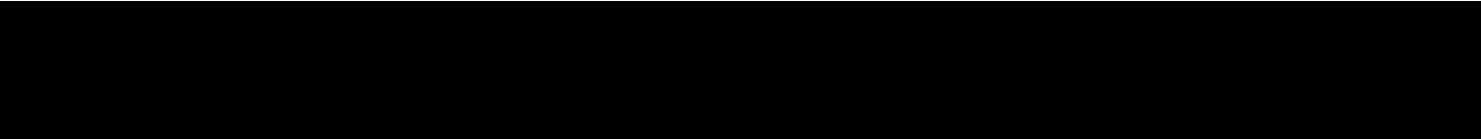
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/10/2012 2. 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/19/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 04/2015 2. 12/2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. 01/03/2008 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2008	Physician estimate of gestation (in weeks) 8	Post fertilization age of the fetus (in weeks) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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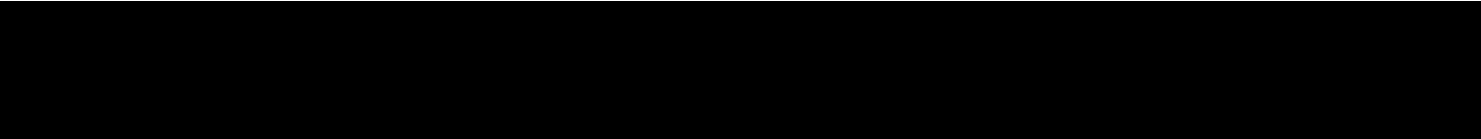
Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

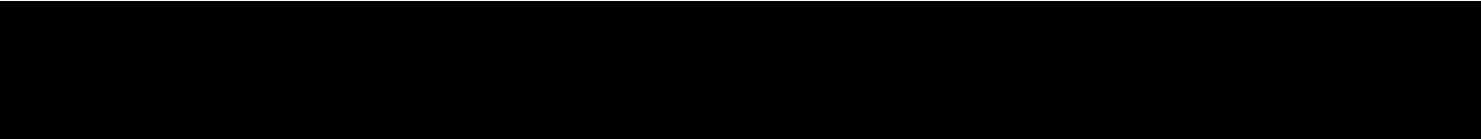
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/2014 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/05/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 12/10/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 04/04/2014 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/23/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (in weeks) 10	Post fertilization age of the fetus (in weeks) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 10/29/2015 2. UNKNOWN 3. UNKNOWN 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/04/2016 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/31/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

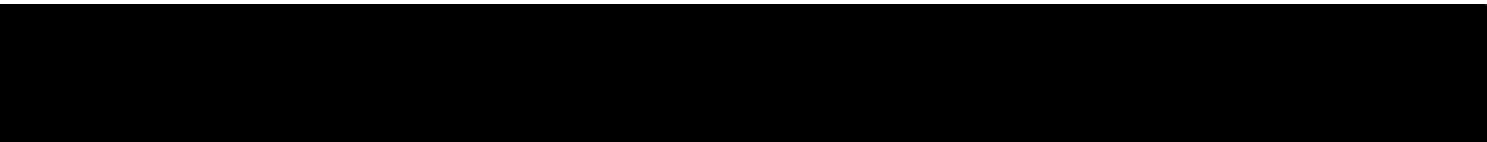
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/19/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/12/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/12/2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 08/06/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/12/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/04/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/27/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/07/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (in weeks) 6	Post fertilization age of the fetus (in weeks) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 03/10/2015 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 07/20/2015 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/16/2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/10/2014 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/11/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 04/04/2014	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/04/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/10/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Unknown
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input checked="" type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 06/14/2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/29/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 4	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 03/17/2010 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 43	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/23/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/03/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Unknown
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 05/30/2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/31/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

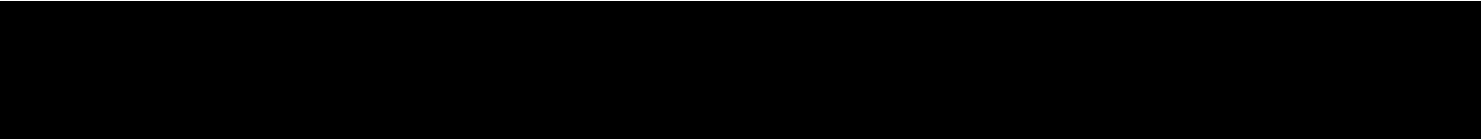
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/29/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (Do not include this termination. If more than six (6), those most recent.)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/03/2016	Physician estimate of gestation (in weeks) 10	Post fertilization age of the fetus (in weeks) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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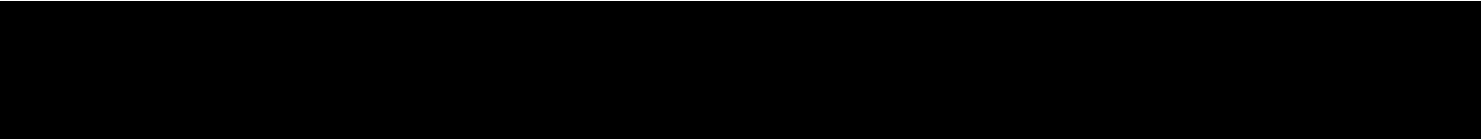
Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/05/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input checked="" type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/19/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 01/26/2016 2. 3. 4. 5. 6.

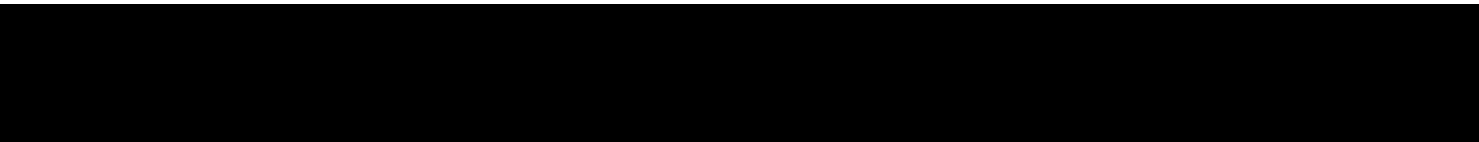
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Did this termination of pregnancy result in a maternal death?
☐ Yes ☒ No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 06/12/2012 2. UNKNOWN 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/19/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 2

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (in weeks) 12	Post fertilization age of the fetus (in weeks) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/08/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/10/2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/06/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

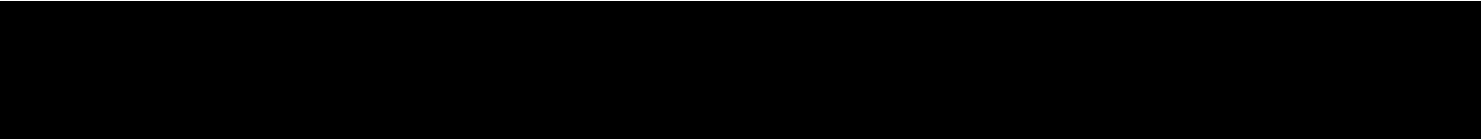
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/09/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/01/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 02/18/2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/31/2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/06/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 19	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/30/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/19/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/09/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/03/2016	Education Doctorate/Professional Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/10/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/24/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/06/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/26/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 05/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/14/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (Do not include this termination. If more than six (6), those most recent.)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/04/2016	Physician estimate of gestation (in weeks) 7	Post fertilization age of the fetus (in weeks) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (number and street, city, state, and zip code) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 10/22/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403	City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/18/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) - 421 SOUTH COLLEGE AVENUE, BLOOMINGTON, IN, 47403		City or town, of pregnancy termination BLOOMINGTON	County of pregnancy termination MONROE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/30/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 05/05/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. CAROL DELLINGER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 S. MERIDIAN ST, INDIANAPOLIS, IN 46225



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016